Colorado Medicaid Prior Authorization Request Form

Viekira Pak (ombitasvir, paritaprevir, ritonavir, dasabuvir) or Technivie (ombitasvir, paritaprevir, ritonavir)

This form **must be signed by prescriber** to request prior authorization for Viekira Pak or Technivie beginning October 1, 2015. See the Preferred Drug List (PDL) for details at: https://www.colorado.gov/hcpf/provider-forms. Certain documentation is required to accompany this form for approval consideration. Prescriber must be a physician and must complete and sign this form.

Please fill in ALL areas on form. Incomplete forms (including missing required lab values or documentation) will result in a PA denial

Member name: _____ DOB: _____

Medicaid ID: _____ Gender: _____BMI: _____ Baseline ALT: _____ CrCl ml/min:_____

Select drug you are requesting: □ **Viekira Pak** □ **Technivie**

This section must be complete AND all documentation must accompany PAR or PA will be denied for incompleteness

Genotype: □ 1a □ 1b (**Viekira Pak only**) □ 4 (**Technivie only**) Pre-tx HCV RNA UI/mL: _____

Child-Pugh Score: _____ (5-9, not A or B) Hep A&B vaccination series □ Completed (provide labs/immunization record) □ In Progress

Any fibrosis? (**must provide labs for Biopsy/APRI/FIB-4/FibroScan/FibroMeter/FibroTest**) □ No □ Yes

Provide scores: Biopsy_____ APRI_____ FIB-4 _____ FibroScan_____ FibroMeter/FibroTest _____

Approvable scores: F3-F4 or F3 >1 or >1.39 >2.2 or >2.2<3.16 >9.6kPa or >9.6<14.6kPa >0.58kPa or >0.58<0.74

Provider attests that member is ready to be compliant to the medication regimen □ Yes

Provider attests that member will be enrolled in the Abbvie proCeed Nurse Connector Program □ Yes

Provider attests that SVR12 and SVR24 will be submitted timely via fax □ Yes

History of drug/alcohol misuse/abuse? □ No □ Yes

Has member been drug/alcohol free for at least 6 months? □ No □ Yes

Attached screens (not more than 30 days old) □ Marijuana □ Toxicology □ ETOH

ALL members must provide initial drug/alcohol screen documentation which must include marijuana. Provide random monthly screens during treatment if member has **history of misuse/abuse within last 2 years**

Prior Treatment: □ No □ Yes **Describe with approximate dates**: _____

Indicate member's diagnosis(es) (provide documentation):

□ Chronic Hepatitis C □ Hepatitis B □ Cirrhosis: □ CTP A □ CTP B

□ HIV/AIDS □ Post-transplant □ On transplant list with less than 1 year on the list projected

□ Ascites □ Variceal bleed □ Hepatic encephalopathy □ Leukocytoclastic vasculitis

□ Membranoproliferative glomerulonephritis □ Symptomatic cryogobulinemia despite mild liver disease

□ Hepatocellular carcinoma meeting Milan criteria □ End-Stage Renal Disease requiring hemodialysis

Complete current medication list required. Attached? □ Yes

Is member taking (circle) alfuzosin, carbamazepine, phenytoin, phenobarbital, ergot derivatives, ethinyl estradiol-containing products, fluticasone*, voriconazole, salmeterol, St. John's wort, lovastatin, simvastatin, gemfibrozil*, rifampin, pimozide, efavirenz, darunavir, lopinavir, rilpivirine, sildenafil, triazolam, oral midazolam (*Viekira Pak only) □ **None**

Technivie only: Is member taking moderate or strong CYP3A inducers □ No □ Yes

Female members: Is member of childbearing potential? □ No □ Yes (provide pregnancy test)

Is requested drug being prescribed in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist?
□ No □ Yes Identify provider and specialty (circle above)_____

Initial approval: 8 week supply. Refills: not granted unless required documentation is received.

Physician: _____ Phone: _____ Fax: _____ NPI: _____

Physician signature: _____ Date: _____

(Must be signed by PHYSICIAN for attestation)

Effective January 1, 2016 **Please fax complete form and supporting documentation to 888-772-9696**